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ABSTRACT

This report was written as part of an attempt by the state of Vermont to significantly decrease the number of adolescents involved in self-destructive and suicidal behaviors. It focuses on schools as a starting point to preventing youth suicide in Vermont. The introduction outlines the extent of the problem of adolescent suicide. The remainder of the report is divided into three sections focusing on primary prevention, secondary prevention or intervention, and tertiary prevention or treatment. The section on primary prevention offers recommendations in the areas of parenting education, school climate, curriculum, stress and depression management, physical fitness management, nutrition management, safety, developing a written protocol, the Vermont Suicide Prevention Resource Center, and peer support. The section on secondary prevention concentrates on faculty and staff education and helping parents prevent youth suicide. The tertiary prevention section presents recommended protocols for use in dealing with a potential suicide, following a suicide attempt, and following a completed suicide. A bibliography is included. A sample brochure to send home with report cards, a list of areas of concern and recommendations, a description of the Vermont Prevention Training Team, and a list of professional resources are appended. (NB)

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ED297244

The Lieutenant Governor's Task Force on

YOUTH SUICIDE PREVENTION IN VERMONT

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Howard Dean, M.D.
Lieutenant Governor
May, 1988

CG 021026

Report of the Lieutenant Governor's Task Force on

YOUTH SUICIDE PREVENTION IN VERMONT

Howard Dean, M.D.
Lieutenant Governor, 1988

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LIEUTENANT GOVERNOR

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Dear Vermonter:

Most of us would agree that young people are our most important asset. There has been an alarming rate of increase in young people taking their own lives in this country and in the State of Vermont over the last decade.

I very much appreciate the unselfish efforts of the members of this task force who put in many hours with no pay to come up with this report. I hope you will find it to be a practical and easy-to-understand manual. It is my hope that every school in the state will consider the issue of teen suicide and what we can do to prevent it.

There is no legislation needed for this effort, since this report suggests no mandates for school systems. However, even during the time we were working on this report we were bombarded with phone calls from educators, parents, and mental health professionals who wanted to know what we could do to help.

In addition to the very practical suggestions in this report, we are also recommending the establishment of a Vermont suicide prevention resource center and good coordination between mental health facilities and the school systems. We hope that you will feel free to contact me or any of us on the task force if you have questions about general implementation of our recommendations or if you have a specific question which we could help to resolve by sending someone to your area.

Sincerely,

Howard Dean M.D.

Howard Dean, M.D.
Lieutenant Governor

HBD:jfw

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INTRODUCTION

Every year, approximately 5,000 young people nationwide are confirmed by post-mortem to have killed themselves. Over recent years, for reasons that are not at all clear, this rate has been rising to the point where suicide is now the third leading cause of death for adolescents after accidents and homicides.

As the rate has risen, so has our concern and our interest. We now know, for instance, that the increase has predominantly been among white males. In fact, the majority of adolescent suicides fit the following profile: white older adolescents who have a history of behavior problems, a family history of suicidal behavior and violence, use of substances especially alcohol, and completion of suicide with a gun.

Vermont closely parallels the national scene. At present the adolescent suicide rate in Vermont is 8th in the nation. Whereas the national rate is 11 per 100,000, in Vermont it is 14.6 per 100,000. With respect to our demographics, the typical adolescent suicide apparently closely matches the national profile. In Vermont, it is second only to accidents as the leading cause of death.

Paralleling the increased completed suicide figures has been an increase in the number of adolescents attempting suicide. A conservative estimate of the number of adolescents performing self-destructive acts is 100 to 200 times the completed suicide numbers. These adolescents are typically younger substance-abusing females who feel sad. They normally utilize a non-lethal method. By virtue of their numbers, this group is consuming large amounts of emergency room and mental health service.

It is estimated that no less than 10% of adolescents nationwide will experience significant suicidal ideation this year. Clinical experience indicates a similar problem here in Vermont.

When we put these figures together, we can see that these groups present Vermont with a serious challenge. Large numbers of our adolescents contemplate, attempt, and complete suicide. We feel these figures are too high and hence present the following report as a part of our attempt to significantly decrease the number of adolescents involved in self-destructive and suicidal behaviors. Given the extent of the problem we will be focusing on schools as a starting point to preventing youth suicide in Vermont.

PRIMARY PREVENTION

The prevention of adolescent suicide can be viewed on three levels: primary prevention, secondary prevention (intervention), and tertiary prevention (treatment).

PRIMARY PREVENTION of teenage suicide means efforts to reduce the likelihood that young people will experience the kinds of feelings which cause them to seriously consider suicide. Such efforts are designed to promote a sense of well being within the general population by:

- building healthy self concepts (perceptions of self-worth, competence, significance, belonging, and having power or control over one's life)

- building skills (problem-solving, decision-making, coping, judgment, self-control, communication, responsibility)

- providing supports (peer support, positive peer influence, someone to share problems and concerns)

- increasing awareness through information and discussion about life and feelings.

Examples of primary prevention activities include:

- parent education/parenting skills

- improvement of school climate

- comprehensive school health curriculum

- peer support

- school guidance and counseling services

- general community education.

It is not enough to respond early and well to young people considering suicide. It is important to enable young people to understand their feelings and know how and when to ask for help.

Teenagers make decisions based on how they perceive themselves and their world. Those who have healthy self concepts are less likely to make a decision to attempt suicide.

To help young people acquire healthy self-perceptions is the first goal of prevention. These perceptions are gained primarily from how young people are treated in the family and in school. Peer influence plays a strong role but can assert itself negatively if the family and school influence has not been constructive. Thus, working with families and schools to help them develop healthy self concepts in their children and students becomes an essential strategy.

PARENTING EDUCATION

Most parents could benefit from learning skills which promote healthy self-perceptions in their children. Parents can learn many of these skills by attending such parent education courses as Developing Capable Young People, The Nurturing Program, Active Parenting, STEP and STEP TEEN, or others. The particular course recommended depends on the age of the child, availability, and individual preference. Parent-child centers, where they exist across the state, are currently the best source of information about parenting courses. The earlier a parent learns these skills the better, but it is never too late. We recognize that some parents are reluctant to attend formal courses, and alternative approaches are therefore necessary.

Recommendations:

1. That a variety of parent education courses be made available on a systematic and regular basis in every community in the state.

2. That school systems become more involved in offering these courses to the community in cooperation with area parent-child centers where possible.

3. That alternative parent education strategies be developed for those parents unreachable through formal courses, post-birthcare on up, to create a solid foundation from which all further perceptions and actions can build.

SCHOOL CLIMATE

School policies and practices appear to have as equally an important influence as the family on the development of self-perceptions. These policies and practices should be examined with regard to how they affect the perceptions of students. "School climate" improvement strategies are already required as part of the Vermont School Approval Standards. However, many school systems lack guidance in how to effectively bring this about.

Recommendations:

1. That each school system in the state conduct an assessment of its "climate" in relation to its effect on student perceptions. This should include, but not be limited to, an examination of:

- school discipline policies and practices
- instructional practices
- student governance
- curricular relevance to life outside school
- tracking, ranking, and grading practices

Once such an assessment is conducted the school should make the indicated changes to ensure the development of healthy self-perceptions in all students. This may include providing inservice training for teachers on effective discipline and/or instruction of students.

2. That the Department of Education provide substantially increased technical and financial assistance to schools in promoting healthier school climates.

CURRICULUM

Our schools can serve as an appropriate vehicle for providing information and developing skills with almost all of Vermont's young people. Health education already provides many opportunities to teach students how to cope with many of the problems which lead to such a desperate act as suicide. But teachers will need appropriate training, support systems, and accompanying curriculum materials to successfully teach students about such a delicate topic.

We must be very sensitive as we bolster this part of the comprehensive health education curriculum. There are many extremely important life-threatening issues which are presently competing for attention in the curriculum such as AIDS, alcohol and drug abuse, and teen pregnancy. While school personnel have had recent experience integrating one of these sensitive issues, alcohol and drug education, into the health education curriculum, teachers are feeling overwhelmed by the load of societal ills which they feel they are expected to solve. Also, parents are very concerned about what schools teach about these issues, how the subject matter is handled and at what level the topics are addressed.

Where Does Suicide Prevention Fit in the School Curriculum?

Although some of the skills related to healthy living, self-esteem and decision-making are included in the Department

of Education's standards for elementary (K-4) and middle grades (5-8) curriculum, most of the content addressing the topic of suicide would be most appropriately included in the high school (grades 9-12) curriculum. The comprehensive health education curriculum includes opportunities to present the skills and concepts of self-esteem, personal well-being, responsibility to others, decision-making, coping, interpersonal relationships and stress management. Many of these topics can also be addressed in an integrated approach involving other related curriculum areas.

What Should Be the Curriculum Content

In preparing to introduce a suicide prevention curriculum into a school, it is critical that the teaching and support staff have identified and agreed on goals.

The school curriculum dealing with the issue of suicide must be chosen very carefully. A curriculum that emphasizes common and general problems of adolescents must label suicide as maladaptive behavior. Imitation of suicidal behavior may be most likely to occur if suicide is presented as a tragic response to a common stress of adolescence. When a curriculum goal for the students is an increase in knowledge about suicide, its presentation should include the importance of prior personality and/or behavior difficulties and adolescent risk factors.

If a school is introducing a suicide prevention curriculum, it is important that one of the goals of that curriculum introduction be the imparting to students information about what their local help resources are and how these resources can be expected to respond and help. This goal requires that school personnel have developed, before the introduction of the curriculum, a directory of in-school and in-the-community resources that can be accessed either by a staff member on behalf of a student or by a student him/herself. It is imperative that a process and procedure for accessing a "helper" be an ongoing guarantee to students and cannot be viewed by school personnel as necessary only during the life of the suicide prevention curriculum itself.

The curriculum content should focus on three basic areas: awareness, education for living, and life management skills. Students need instruction to be conscious of how they might be aware of a possible suicide. This part of the curriculum should be coordinated with the referral and support systems within the school and community. Students must understand why a person, including a teenager, would consider suicide. They must be made aware of the signals which might indicate suicidal behavior. Students must know what prevention resources are available and how to access them.

We pay a great deal of attention to educating young people to prepare them to earn a living. We must also be certain that they learn how to live healthy, productive lives. Millions of dollars are spent each year on treatment and rehabilitation programs, but only one-tenth of one percent of that amount is spent on teaching skills related to prevention. It is important that the comprehensive health education curriculum be based on prevention and be linked to appropriate suicide intervention procedures.

The health education curriculum emphasizes factual information and includes coping and decision-making skills. An equally important component might be referred to as life management skills. This group of skills would include the following:

STRESS/DEPRESSION MANAGEMENT

Recent information concerned with suicide indicates that some students do not know how to deal with the stress in their lives. Depression can result from their inability to deal with pressure to succeed, family problems, broken romances, fear of the future, loss of someone or something, feeling of not being listened to, sense of worth, loss of hope, and lack of roots. It compounds the situation when you add the stress of poor eating habits, sleeping habits, lack of physical fitness, and other environmental conditions.

Recommendations:

1. The curriculum should assist students to develop sets of skills to identify stress in their lives.

2. After identifying the causes of stress, students should have the information and skills necessary to cope with these stress points.

3. We should pay particular attention to the crisis years of pre-adolescence and adolescence.

PHYSICAL FITNESS MANAGEMENT

The latest research concludes that today's youth are the least physically fit generation ever. To live in today's stressful environment requires a great deal of energy and self-discipline which can be gained through being physically fit.

Recommendations:

1. The school program should include physical education, emphasize fitness, and be oriented toward the development of skills necessary for team and individual sports.

2. The program should provide sufficient time to allow elementary and secondary students to develop their cardiovascular systems (a minimum of three times per week where they are exercising their hearts for 20 minutes at their target heart rates).

NUTRITION MANAGEMENT

It takes energy to survive in a fast-paced society. In addition to energy we need a balance of all nutrients to ensure a proper chemical balance within our systems. To date much of our nutrition education is geared to disseminating information rather than providing the opportunity to build the practical skills necessary for managing one's eating behaviors.

Recommendations:

1. The school lunch programs should reflect good nutrition.

2. The curriculum should tie nutrition education to a concern for fitness and its importance in managing stress.

SAFETY

Injuries are the leading cause of death until people reach age 65. We know that a significant number of these could be classified as suicides, especially those involving automobiles. If we are to be successful in reducing accidents, we must do something more than dispense information.

Recommendations:

1. The safety curriculum should concern itself with in-depth probing of student safety attitudes.

2. The program should address the availability of guns and relate it to the fact that, of those who have committed suicide, 70% of the males and 35% of the females used guns.

3. The curriculum should address the consequences of high-risk behaviors.

4. The curriculum should tie together safety issues and their relationship to managing stress, one's level of fitness and one's nutrition habits.

DEVELOPING A WRITTEN PROTOCOL (See Recommended Protocols under TERTIARY PREVENTION, pp.18-25)

Suicide prevention programs in Vermont schools must be designed with the utmost care. Before students, teachers, and parents take part in prevention education programs each school must have a written protocol describing the steps that are to be taken when a student expresses suicide ideation, makes suicide gestures, or is perceived to be at risk of suicide. Without this protocol, school personnel who become trained in identifying students at risk of attempting suicide will become frustrated and disillusioned about sharing this information.

It is essential that local community members who are skilled in dealing with students at risk of suicide be involved in the protocol implementation and that all school personnel be provided inservice training regarding the protocol.

VERMONT SUICIDE PREVENTION RESOURCE CENTER

The Task Force recognizes the necessity of establishing a Vermont Suicide Prevention Resource Center to provide technical expertise to any school developing suicide prevention curricula and related training for teachers, parents, and students. The center would review the vast number of suicide curricula now being produced, select appropriate curriculum models and audio-visual materials, keep up to date with the research in this field, and share information about crisis management.

The need for highly skilled technical assistance in this area cannot be over emphasized. Without such assistance expecting teachers to be sufficiently knowledgeable and comfortable in discussing this subject with students is unrealistic. If we encourage schools to establish suicide prevention programs without such a resource, we will be instrumental in creating more problems than solving them.

Recommendations:

1. Information on suicide prevention should be included in the Comprehensive Health Education curriculum, which provides ample opportunity throughout grades kindergarten to twelve to address this delicate topic.

2. The curriculum content which specifically addresses the topic of suicide should be first introduced in the middle grades.

3. The curriculum focus should be on the positive aspects of life-management skills, including coping, decision-making, self-esteem, and stress management. It is critically important that suicide is not presented to students as a tragic response to the common stress of adolescence.

4. A statewide Suicide Prevention Resource Center should be established to serve as a clearinghouse and provide technical expertise to schools developing suicide prevention curricula and related training for students, parents, and educators.

5. Schools should be brought into compliance with the Comprehensive Health Education curriculum requirements in the Standards for Approving Vermont's Public Schools.

PEER SUPPORT

Schools should also be promoting the positive influence of peers on one another, including the creation of an atmosphere where young people feel comfortable sharing their concerns and problems. Sometimes peers experiencing problems will open up to each other before they will open up to a practitioner.

Recommendations:

1. School systems should consider establishing effective peer support programs and/or student assistance programs which draw out and help to resolve perceived problems and ensure that appropriate referrals are made when necessary.

2. School systems in the state should consider becoming involved with a group like the Green Mountain Teenage Institute which, while primarily focused on alcohol and other drugs, has a very positive general influence on teenagers.

3. More programs should be developed like "Alternatives for Teens" in Addison County, where people not only plan chemical-free events for each other, but feel comfortable sharing concerns and problems in a safe setting.

4. Other programs to combat alcohol and drug abuse should be expanded, such as Students Against Drunk Driving.

5. More teenage discussion groups should be established, beginning in junior high school.

SECONDARY PREVENTION

Secondary prevention includes efforts designed to intervene at the earliest possible time with adolescents who are thinking, verbalizing, or in some other way communicating their intent to die.

FACULTY AND STAFF EDUCATION

In Vermont, many school faculty and administrators have identified suicide prevention as a top priority for faculty and staff education. Both the Department of Education and the Department of Mental Health have a list of speakers who are capable of conducting workshops on youth suicide. Although there are many perspectives on this subject, the most important tasks for faculty and staff are identifying students at risk and understanding what to do for the safety of a student. The following excerpt from "Young People in Crisis, How YOU Can Help" by Pamela Cantor, President of the National Committee on Youth Suicide makes some suggestions:

Recognizing the Risk

Rarely do young people in crisis really want to die. But they may feel that they have no reason to go on living.

Those who attempt or commit suicide often fear that their lives will always seem empty, painful, meaningless. And they believe there is nothing they can do to change that.

These troubled young people are looking for someone who can help them deal with their overwhelming sense of hopelessness and helplessness. That's why almost everyone who attempts suicide tries to let someone else know that for them the pain of living has become unbearable.

The young person at most serious risk of suicide is one who has:

- Made a suicide attempt or gesture
- Discussed or threatened suicide
- Made specific plans to commit suicide and has given away prized possessions
- Been preoccupied with death
- Known someone else who has committed suicide.

Depression is one of the main warning signs. It may be rooted in such things as divorce, a move to a new town or school, failure to become a member of a sports team, inability to sustain a romantic relationship. It may be disguised by apparent cheerfulness or serenity. It may also lead to a suicide attempt.

Behavioral changes are common clues to depression. Mood swings are normal in adolescence, but a sudden, dramatic change may be an effort to cope with pain. Any uncharacteristic behavior that persists for more than a few weeks should be cause for concern. Other warning signs include:

- Isolation or withdrawal from family, friends, or activities
- Eating too much or too little
- Sleeping too much or too little
- Unexplained fatigue
- Apathy
- Unexplained bruises
- Hostility
- Indecisiveness
- Alcohol or drug abuse
- Lack of concentration
- Inability to feel good about oneself or to express joy
- Crying for no apparent reason
- Thinking, writing, or talking about death or dying
- Acquiring a weapon.

It is difficult to acknowledge clues that seem to indicate someone you care about may be planning to commit suicide. But it can be tragic to disregard them.

<u>You Can Help</u>

As a teacher, guidance counselor, board member, administrator, school nurse or support staff, you can help. The important thing is that you want to help. And someone like you--listening, watching, caring--can make a difference between life and death.

You don't have to have years of training. But you have to learn to listen carefully enough to understand the problem. And you have to care enough to help find the solution. You can help by learning the warning signs. If a student you know seems troubled, voice your concern. Let that student know you are concerned and want to help. Learn the protocol and policy in your school and share your concern with the guidance staff or other school personnel.

Be Part of the Solution

Adolescent suicide is wasteful maladaptive behavior, a terrible choice made by young people who feel they have no other choice and who are unable to perceive alternatives to the pain that envelopes them.

Every young person who attempts or considers committing suicide is precariously poised between life and death. You can tip the balance by noticing, by trusting your instincts, by caring enough to get involved.

Recommendations:

1. Each school should develop an emergency staffing team that would intervene if a suicidal student is identified. The team should include, but not be limited to, the school nurse, guidance counselor, and one administrator or designee. Other members, such as concerned teachers, should be included.

2. All staff from each school should have at least two hours of training regarding the warning signs and symptoms of youth suicide.

3. There should be additional training for the emergency staffing team. This should include how to access community and state resources. The emergency staffing team would share the responsibility for the continuing education for the remaining staff. All staff should be trained at least every other year.

4. Each school should develop written protocol and policy regarding action to be taken if a suicidal student is identified and/or in the event of a completed suicide. (See protocol under TERTIARY PREVENTION)

HELPING PARENTS PREVENT YOUTH SUICIDE

Parents need to be made aware of the warning signs of adolescents who are experiencing serious depressed or suicidal feelings. They need to know that depression and suicidal feelings are treatable behavior disorders.

Recommendations:

Schools should provide opportunities for parents to be educated regarding the following issues:

For interested parents who are asking questions

- Programs on adolescent development
- Offered two times a year by the PTO or similar group
- Presenters from community mental health centers or a speaker's bureau

- Topics could include:

    1. Helping adolescent deal with feelings of alienation, loneliness, and stress.

    2. Dealing with adolescent who feels unloved or unwanted.

    3. Need for adolescent to have caring adults outside of family.

    4. How to deal with suicidal threats, notes, and statements.

    5. Safety issues: guns, sexual safety, drugs and alcohol.

- Educated parents used as resource people for other parents and community members.

Parents who do not attend meetings

- Flyer, single page on safety
- To accompany report card twice a year. (See Appendix for sample)

TERTIARY PREVENTION

Tertiary prevention includes efforts to treat or intervene with a potential suicide or measures to take following a suicide. The enclosed recommended suicide occurrence protocols provide procedures for the school in the following cases:

1. A potential suicide
2. Following a suicide attempt
3. Following a completed suicide.

A faculty/staff workshop should be developed to explain these recommended protocols. Appropriate outside consultants should be utilized to provide inservice and to initiate a future support network for the school.

RECOMMENDED PROTOCOL--POTENTIAL SUICIDE

If a staff member or other person believes that a student is demonstrating symptoms of potential suicide (s)he will proceed with the following steps:

1. Report the concerns to the principal and/or the designated coordinator of the Emergency Staffing Team. The team will consist of an administrator, guidance counselor, school nurse, and others as determined by the team, and a liaison representing the backup Mental Health facility.

2. The coordinator will convene an immediate meeting of the team with the referring staff member to evaluate the referred case for appropriate follow-up.

3. The team will designate an appropriate person to meet with the potentially at-risk student to help determine the seriousness of the situation and to report the finding to the team. The following questions may be useful as part of this intervention interview:

If a student has suspected suicide potential

1. Do you find that you're accident prone?

2. Do you drink or use other drugs when things aren't going well?

3. How have you been eating and sleeping?

4. How have your grades been lately?

5. How are things going with your friends?

6. Have you ever wanted to be dead?

7. Why would you want to be dead?

8. Have you ever thought of killing yourself?

If a student has acknowledged suicidal thoughts

1. How long have you been thinking about this?

2. When you are thinking of suicide, how long do the thoughts stay with you?

3. Have you discussed this with anyone?

4. How much do you want to die? (1-3 continuum)
1-little, 2-moderate, 3-great

5. How much do you want to live? (1-3 continuum)
1-little, 2-moderate, 3-great

6. On a scale from 1 to 10, what is the probability that you will kill yourself?
1-little possibility, 10-great possibility

7. Do you have a plan? (get details) or:
Have you thought about how you might kill yourself?

8. Are you now, or have you been, in regular counseling or therapy? When, where, and with whom?

4. If the team decides the student is at risk, a professional assessment for potential suicide risk should be made. This assessment is available through the Community Mental Health Center's 24-hour Emergency Services Division or may be arranged with other appropriate mental health professionals. This assessment shall include recommendations for appropriate follow-up.

5. The coordinator will contact the parent/guardian to:

A. Make them aware of their child's situation

B. Offer assistance for appropriate referrals or arrange a contact with the child's therapist

C. Apprise them of the Community Mental Health Center 24-hour emergency telephone number

D. As a follow-up, a letter will be written reminding the parent/guardian to seek further professional assistance.

6. If it is determined during the preliminary meetings that problems such as suspected abuse are involved, then appropriate referrals must be made in accordance with state law and school policy.

7. The coordinator will inform the superintendent of schools of the events.

RECOMMENDED PROTOCOL--FOLLOWING A SUICIDE ATTEMPT

1. The school nurse should make an immediate assessment of the student's physical condition and take any immediate action necessary to provide medical care to the student.

2. Report the suicide attempt to the principal and/or the designated coordinator of the Emergency Staffing Team. The team will consist of an administrator, guidance counselor, school nurse, and others as determined by the team.

3. The coordinator will inform the superintendent of schools of the events.

4. Inform the parent/guardian.

5. The coordinator will call an immediate meeting of the Emergency Staffing Team to institute an immediate referral for assessment and treatment planning. This service is available through the County Mental Health 24-hour Emergency Services Division, or may be arranged with other appropriate mental health professionals.

6. The coordinator will discuss the incident with the parent/guardian, offer assistance for appropriate referrals and apprise the parent/guardian of the 24-hour Community Mental Health emergency number.

7. If it is determined during the preliminary meetings that problems such as suspected abuse are involved, then appropriate referrals must be made in accord with state law and school policy.

8. The Emergency Staffing Team will arrange for the notification of teachers and other staff members as follows:

A. Call in the teachers of the specific student, including the homeroom teacher, coaches, and other staff who might have regular contact with the student in order to:

1. Inform them what has happened and provide an opportunity for them to deal with their feelings.

2. Discuss how teachers might wish to deal with this in class:

a. Teachers can present the facts as they understand them. It will be helpful to provide a brief written statement of facts that teachers could read in class.

b. Provide some time for students to express feelings.

c. Teachers need to dispel any rumors which might emerge and discourage glorification of the suicide act.

d. It is appropriate for teachers to acknowledge the pain, guilt, and other emotions felt by everyone and to encourage students to go to the guidance office for support:

(1) Provide crisis center hotline phone number

(2) Provide the phone numbers of teachers who are willing to serve as support for students.

e. Ask teachers for the names of students with whom the victim was friendly--those who sat near him/her in class, etc.

9. Send a brief note to other faculty members informing them of the facts and encouraging them to follow the guidelines outlined (in 8.A.2. above).

10. Contact community psychological support services such as Mental Health, Youth Services, and private service providers to let people know what has happened and discuss the possibility:

A. That you will be referring other at-risk students to them for assessment

B. Of their coming into the school to provide direct support for students and staff.

11. Try to be aware of your own feelings and ability to function professionally. If you're not sure you will be able to, get help from others.

12. Attempt to identify students who might be particularly affected by the suicide attempt such as:

A. Relatives

B. Friends

C. Classmates/teammates

D. Students with a history of suicidal ideation, depression, or substance abuse.

13. Decide how to inform the entire student body in a manner that avoids unintended glorification of the act as well as volatile emotional scenes.

A. If a student assembly is held, it is important that the principal reiterate the facts as provided in the written statement teacher read earlier (see 8.A.2.a) and add any new facts that may be available.

B. Inform the school community that the school will provide any appropriate updated information if necessary.

14. Hold a faculty meeting for staff at the end of the day. The school may request an outside psychological support person be present for this meeting which would:

A. Give staff an opportunity to process what has happened

B. Provide an opportunity to discuss the students that the staff may perceive as having a particularly difficult time with the suicide attempt and may be identified as high-risk students

C. Provide time for any further planning strategies, if necessary.

15. Establish a special time to meet with parents/guardians of high-risk students. A designated person or persons will contact parents/guardians of high-risk students by telephone to initiate such a meeting.

16. Reestablish an air of normalcy as soon as possible.

17. Provide ongoing support for students and staff as needed.

RECOMMENDED PROTOCOL--FOLLOWING A COMPLETED SUICIDE

1. Report received by a school official who will notify the principal who will notify the coordinator of the Emergency Staffing Team.

2. The principal or the coordinator will determine the legitimacy of the report and notify the superintendent of schools.

3. If the report is factual and school is in session, an immediate meeting of the Emergency Staffing Team will be held to arrange for notification of teachers and other staff members using the steps in 4A and B below.

4. If the report is factual and school is not in session, a prearranged chain telephone calling system will be used to notify all faculty and staff prior to their arrival at school. If possible, before school begins:

A. Call in the teachers of the deceased student, including the homeroom teacher, coaches, and any other staff who might have had regular contact with the student in order to:

1. Inform them what has happened and provide an opportunity for them to deal with their feelings

2. Inform them of the location of a student support center

3. Discuss how teachers might wish to deal in class with the suicide:

a. Teachers can present the facts as they understand them. It will be helpful to provide a brief written statement of facts that teachers could read in class.

b. Provide some time for students to express feelings.

c. Teachers need to dispel any rumors which might emerge and discourage glorification of the suicide act.

d. It is appropriate for teachers to acknowledge the pain, guilt, and other emotions felt by everyone and to encourage students to go to the student support center.

(1) Provide crisis center hotline phone number.

(2) Provide the phone numbers of teachers who are willing to serve as support for students.

e. Ask teachers for the names of students with whom the victim was friendly--those who sat near him/her in class, etc.

B. Send a brief note to other faculty members informing them of the facts and encouraging them to follow the guidelines outlined (in 4.A.3. above).

5. Contact community psychological support services such as Mental Health, Youth Services, and private service providers to let people know what has happened and discuss the possibility:

A. That you will be referring other at-risk students to them for assessment

B. Of their coming into the school to provide direct support for students and staff.

6. Try to be aware of your own feelings and ability to function professionally. If you're not sure you will be able to, get help from others.

7. Attempt to identify students who might be particularly affected by the death such as:

A. Relatives

B. Friends

C. Classmates/teammates

D. Students with a history of suicidal ideation, depression, or substance abuse.

8. Decide how to inform the entire student body in a manner that avoids unintended glorification of the act as well as volatile emotional scenes.

A. If a student assembly is held, it is important that the principal reiterate the facts as provided in the written statement teachers read earlier (see 4.A.3.a.) and add any new facts that may be available.

B. Provide information if a memorial service is to be held.

9. Hold a faculty meeting for staff at the end of the day with an outside psychological support person present. This meeting:

   A. Gives staff an opportunity to process what has happened

   B. Provides an opportunity to discuss the students that the staff may perceive as having a particularly difficult time with the death

   C. Provides time for planning strategies for the upcoming days.

10. Establish a special time to meet with parents/guardians of high-risk students. A designated person or persons will contact parents of high-risk students by telephone to initiate such a meeting.

11. If appropriate, and utilizing consultants, conduct an informal meeting to provide both information and support to the community-at-large.

12. Provide time for students, faculty, and staff who wish to attend the funeral. The school should remain open in order to discourage glorification of the suicide act. This also provides ongoing support for students and staff to maintain the school functioning.

13. Determine time and procedures to assume closure of the event and reestablish an air of normalcy as soon as possible.

14. Follow-up.

   A. Provide ongoing support for students and staff as needed, including being aware of anniversary date or other significant dates affecting students.

   B. A letter will be written to the parent/guardian of all high-risk students advising them to seek professional assessment for their child.

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APPENDIX A

SAMPLE BROCHURE TO SEND HOME WITH REPORT CARD

Is Your Child Safe?

Do you see that he/she wears seat belts?

Does he/she know about the damage alcohol and drugs can do to his/her life?

Does he/she know that drinking and driving is a fatal combination?

If he/she seems depressed, talks about hurting or killing himself or herself, do you know what to do? Take it seriously; find help from someone you trust--school personnel, doctor, mental health clinic, minister, priest, rabbi--

Be concerned if your child spends most of the time in his room, doesn't mingle with the family...

Ask if (s)he is all right. If not, get help, and TALK.

APPENDIX B

In developing this report, the committee chose to make some pragmatic decisions concerning the scope of what can be done in this area. As can be seen from reading the report, we, in fact, chose to limit the primary emphasis to the education system.

It was clear to us all, however, that in order to have a comprehensive approach aimed at decreasing suicide other areas would need to be addressed as well.

The following are other areas of concern:

I. ACCESS TO LETHAL METHODS

Nationwide and in Vermont, the majority of youth suicides are completed with guns. Most frequently, these are handguns and they belong to an adult family member of the victim.

We know that adolescents who truly want to die choose what they know to be lethal methods and guns provide an obvious example of this.

Given the current social political climate, the committee does not believe that gun control is a realistic position. This is unfortunate since we know from other countries, specifically England and Australia, that limiting legal methods provides a very positive and dramatic way to decrease the suicide rate.

Recommendation:

Continue and increase education concerning gun safety.

II. SUBSTANCE ABUSE

We know that prior to their suicides a great number of adolescents have been drinking alcohol and also frequently have been using other drugs. We know that substance abuse in general increases impulsivity and hence may make a suicide more likely.

Recommendations:

A. Every reasonable attempt should be made to limit adolescent substance abuse.

B. Continue the substance abuse education currently occurring in schools.

C. Encourage schools to develop substance abuse counseling for those adolescents who are identified as abusing.

III. FRAGMENTATION OF SOCIAL SERVICES

As a general comment, Child and Adolescent Services in Vermont are fragmented. With respect to individual clients, typically this means that individuals involved are not receiving comprehensive evaluations and interventions. Rather evaluations and interventions are being developed from the perspective of the service provider. These lead to two fundamental problems. First, suicidal patients are not being identified by care-givers, and second, the expertise of one group of care-givers is not being made available to others.

Recommendation::

Every effort needs to be made to encourage Social and Rehabilitation Services, Mental Health, Education, Corrections and Vocational Rehabilitation to coordinate services.

IV. VIOLENCE IN THE FAMILIES

Suicide is a violent act. Clinicians frequently observe that suicidal youths have been exposed to both physical and sexual abuse prior to attempting or completing suicide.

Recommendations::

A. Continue to support the broad-based social and legal efforts to limit violence in families in Vermont.

B. Provide education in schools concerning the harmful effects of violence upon children.

V. LACK OF A SECURE LOCKED FACILITY TO PROVIDE MENTAL HEALTH SERVICES FOR SERIOUSLY SUICIDAL YOUTH IN VERMONT

At the present time Vermont has very limited facilities for suicidal youth. We lack specialized facilities that are regionally based that can deal with the very seriously suicidal. Specifically:

A. Children under the age of 18 cannot be committed to the Vermont State Hospital.

B. The Northeastern Family Institute (NFI) in Burlington can take suicidal adolescents; but although it is staff secure, it is not a locked facility and cannot take nonvoluntarily committed patients.

C. The Brattleboro Retreat can take adolescents and is a designated facility for committed patients but is limited by insurance coverage problems.

Recommendation:

Vermont needs geographically located staff-secure and facility-secure adolescent programs which are available to all the seriously suicidal youth who need such a service.

VI. DISCRETE POPULATIONS OF YOUNG PEOPLE THAT THIS REPORT DOES NOT SPECIFICALLY ADDRESS

PRISON POPULATION:

Given that the typical suicidal case is a substance-abusing, antisocial young male, the prison population obviously presents a high-risk group. In order to decrease suicides, every effort has to be made to identify the suicidal individual and to then provide appropriate services.

Recommendations:

A. Adequate pre-sentence screening for suicide.

B. Ongoing inservice education for persons or personnel concerning this issue.

SCHOOL DROPOUTS:

Young people who have dropped out of school are a high-risk group. These young people are a serious concern to the committee because they are not easily identifiable and, so to speak, have dropped through the cracks.

Recommendations:

A. Effort needs to be made to keep children in school until they complete their education.

B. For those who are identified as at high risk of dropping out, an aggressive program of job training needs to be made available.

APPENDIX C

VERMONT PREVENTION TRAINING TEAM

The Vermont Prevention Training Team (VPTT) consists of over 30 trained professionals who are available to assist communities, community-based organizations, schools, service clubs, local and state agencies, and government in the following:

- action planning for the prevention of any and all human service-related problems and the promotion of health and well-being
- creating constructive responses to community crises, such as teenage suicide, sexual abuse, teenage pregnancy, alcohol and drug abuse, truancy, delinquency, etc.
- creating community and institutional conditions which promote well-being
- orientation to the concept of prevention and understanding the practical implementation of prevention.

Upon request, selected members of the VPTT will be deployed to the requesting organization or community to meet the desired prevention training, technical assistance, or orientation needs. All inquiries should be made to:

Brenda Lindemann
Agency of Human Services
Planning Division
103 South Main Street
Waterbury, VT 05676
(241-2229)

APPENDIX D

PROFESSIONAL RESOURCES

Vermont Department of Mental Health:
103 South Main Street
Waterbury, VT 05676

Commissioner's Office	241-2610
Mental Health Division	241-2604
Mental Retardation Division	241-2614
Child and Adolescent Service Systems Program (CASSP)	241-2603
Vermont State Hospital, Waterbury	241-1000
Brandon Training School, Brandon 05733	247-5711

Community Mental Health Centers (by County):

ADDISON COUNTY:
The Counseling Service of Addison County
Mental Health Services
89 Main Street
Middlebury 05753 Tel. 388-6751
24-Hour Emergency Service 388-7641

BENNINGTON COUNTY:
United Counseling Service of Bennington County, Inc.
120 Hospital Drive
Bennington 05201 Tel. 442-5491
24-Hour Emergency Service 442-5491 362-3950

Alcohol and Drug Abuse
120 Hospital Drive
Bennington 05201 442-5491

Northshire UCS
Lundy Building, P.O. Box 538
Manchester Center 05255 362-3950

CHITTENDEN COUNTY:
Howard Mental Health Services
Main Office, 300 Flynn Avenue
Burlington 05401 Tel. 658-0400
24-Hour Emergency Service 656-3587

Pine Street Counseling Center
855 Pine Street
Burlington 05401 658-0404

Child & Family Services at the Brickyard
P.O. Box 48, 89 Main Street
Essex Junction 05452 878-7155

ESSEX, CALDEDONIA AND ORLEANS COUNTIES:

Northeast Kingdom Mental Health Service, Inc.
Main Office (60 Broadview Avenue)
P.O. Box 724
Newport 05855 Tel. 334-6744
24-Hour Emergency Service 334-6744
141 Railroad Street
P.O. Box 214
St. Johnsbury 05819 748-3181
24-Hour Emergency Service 748-3181

FRANKLIN/GRAND ISLE COUNTIES

Franklin/Grand Isle Mental Health Service
Main Office
8 Ferris Street
St. Albans 05478 Tel. 524-6554
24-Hour Emergency Service 524-6554

Champlain Islands Health Service
Grand Isle 05458 372-4687

Enosburg Community Health Center
Enosburg Falls 05450 933-8313

Marshall Center 524-6561

Richford Health Center 848-3829

LAMOILLE COUNTY:

Lamoille County Mental Health Service
Main Office
Washington Highway
R.R. 3, Box 747
Morrisville 05661 Tel. 888-4914 888-4635
24-Hour Emergency Service 911 in county

ORANGE COUNTY:

Orange County Mental Health Services
Main Office (24 South Main Street)
P.O. Box G
Randolph 05060 Tel. 728-4466
24-Hour Emergency Service 1(800)622-4244
4 Highland Avenue
Randolph 05068 728-4466

28 South Main Street
Randolph 05060 728-4466

Route No. 5
P.O. Box 278
Bradford 05033 222-4477

RUTLAND COUNTY:

Rutland Mental Health Services
Main Office (78 South Main Street)
P.O. Box 222
Rutland 05701 Tel. 775-2381
24-Hour Emergency Service 775-1000
Associates in Child and Family
65 Grove Street
Rutland 05701 775-2386

Evergreen Center for Alcohol and
Drug Services
126 Merchants Row
Rutland 05701 775-4388

WASHINGTON COUNTY:

Washington County Mental Health
Main Office (behind Central Vermont Hospital)
P.O. Box 647
Montpelier 05602 Tel. 229-0591
24-Hour Emergency Service 229-0591
Children & Youth Services
9 Heaton Street
Montpelier 05602 229-0586

Substance Abuse Services
15 Gable Place
Barre 05641 479-1081

WINDHAM AND WINDSOR COUNTIES:

Mental Health Services of Southeastern Vermont
Main Office
19 Westminster Terrace
Bellows Falls 05101 Tel. 463-3947
24-Hour Emergency Service 1(800)622-4235
5 Fairview Street
Brattleboro 05301 254-6028

Mountain Valley Health Center
Londonderry 05148 824-5460

107 Park Street, P.O. Box 6
Springfield 05156 885-5781

Gilman Office Complex
Holiday Inn Drive
White River Junction 05001 295-3031

Mt. Ascutney Hospital
Windsor 05089 674-6711

Ottaquechee Health Center
Woodstock 05091 457-3084

Other Providers:

Brattleboro Retreat
75 Linden Street
Brattleboro 05301 Tel. 257-7785

Baird Center for Children and Families
1110 Pine Street
Burlington 05401 Tel. 863-1326

Mountain Affiliates in Psychology
R.R. 2, Mountain Road
Stowe 05672 Tel. 253-7337

Northeastern Family Institute
431 Pine Street
Burlington 05401 Tel. 863-5092

Medical Center Hospital of Vermont
Out-Patient Psychiatry
DeGoesbriand Unit (adults) 656-4560
Burlington 05401 (youth) 656-4563

Parents Anonymous of Vermont
73 Main Street
P.O. Box 829 Tel. 229-5724
Montpelier 05602 1(800)544-5030

University of Vermont Department
of Psychiatry
John Dewey Hall
Burlington 05405 Tel. 656-2670

Vermont Department of Social and
Rehabilitation Services
103 South Main Street
Waterbury 05676
Social Services Division Tel. 241-2100

Vermont Department of Education
120 State Street
Montpelier 05602
Comprehensive Health Education Program 828-3111
Guidance and Health Services Program 828-3124